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ABSTRACT

As of February, 1989, the Special Supplemental Food Program for Women, Infants, and Children (WIC) was serving 3.9 million people, about one-half of them eligible for the program. Although Congress has consistently voted for increases in WIC funding, and some states have increased funds, Congress has not yet provided sufficient funding to serve all who are eligible for and in need of WIC benefits. In an effort to learn more about local and state efforts to expand and improve WIC, the Food Research and Action Center surveyed state WIC directors, nutrition coordinators, and WIC advocates in all 50 states and the District of Columbia. The survey was conducted in 1988 and followed up in 1989. Questions concerned common barriers to participation and successful ways to overcome them; cost-saving methods; innovative outreach techniques; and statewide WIC organizations. Program management issues were examined. This report incorporates findings of the survey and reviews available information on: (1) the impact of participation in WIC on health and nutrition; (2) program growth; (3) who participates in WIC; (4) who is unserved and why; (5) consequences of not serving those in need; and (6) whether persons not served by WIC are served elsewhere. Policy recommendations emphasizing timely, increased federal funding for WIC are included. Appended are data tables, a petition for an assured WIC funding increase, and a list of 111 national organizations endorsing the petition. (RH)

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FEEDING THE OTHER HALF:

MOTHERS AND CHILDREN LEFT OUT OF WIC

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS iv

ABOUT FRAC iv

FOREWORD v

FRAC WIC SURVEY -- 1988 and 1989 vii

EXECUTIVE SUMMARY viii

I. WIC: COST-EFFECTIVE PREVENTIVE NUTRITION 1

A. The WIC Program: Preventive Nutrition 1

B. Requirements for Participation in WIC 1

1. Categorical Eligibility 1
2. Income Eligibility 1

Table 1: National Minimum and Maximum Income Limits 2

3. Nutritional Risk Eligibility 3

C. WIC: A Success Story 3

D. Cost-Effective Prevention 5

II. PROGRAM GROWTH AND PARTICIPATION 6

Growth of the WIC Program 6

Table 2: Participation in the WIC Program, FY 1977 to FY 1988 7

III. THE UNSERVED 8

A. The Eligible and Unserved 8

B. Most Eligible Children Do Not Receive WIC Services 8

Table 3: Estimated Number of Women and Children Eligible for and Participating in the WIC Program, FY 1989 9

C. Women and Infants Unserved in Many States 10

IV. WHY ARE SOME PEOPLE SERVED AND OTHERS NOT? 11

A. The WIC Priority System 11

B. The Push to Serve the Highest Priorities 11

Table 4: WIC Priority Assignment System 12

C. Waiting for WIC: Waiting Lists for the WIC Program 13

V. THE CONSEQUENCES OF NOT SERVING THOSE IN NEED 14

A. Nutrition, Health and Learning: Impacts on Children 14

B. Before They Are Born: Nutrition During Pregnancy 16

C. Helping New Mothers: Nutritional Needs of Breast-Feeding and Postpartum Women 16

VI. ARE THOSE UNSERVED BY WIC SERVED ELSEWHERE? 18

A. What Happens to the Unserved? 18

B. Outreach: The Hard-to-Reach and the Near-Poor 19

VII. RECOMMENDATIONS FOR INCREASING PARTICIPATION IN THE WIC PROGRAM 20

A. Options for Increased Funding 20

1. Federal Funding 20
2. State Funding Options 22

Table 5: State WIC Supplemental and Contingency Funds, FY 1989 23

B. Cost-Saving Measures to Increase the Numbers Served 24

1. Infant Formula Rebates 24
2. Increasing Breastfeeding Rates Among WIC Mothers 25

C. Making WIC More Accessible to Low-Income Women, Infants and Children 26

VIII. SUMMARY 28

IX. APPENDICES

A. Federal Funding vs. Administration Requests (FY 1980 to FY 1989) 29

B. Petition for Assured WIC Funding Increase and National Organization Endorsers 30

C. Federal WIC Funding vs. Budget Resolution Assumptions (FY 1986 to FY 1990) 35

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ABOUT FRAC

The Food Research and Action Center (FRAC) works at the national and grassroots levels to alleviate hunger in the United States. Focusing primarily on improving the federal food assistance programs, FRAC's main activities include: acting as a clearinghouse on domestic hunger for a nationwide network of several thousand groups and individuals; monitoring federal policy developments on food assistance and hunger; providing technical assistance and training to legal services attorneys and anti-hunger activists; and educating the public and policymakers on the extent and causes of hunger and possible solutions to the problem. FRAC is a nonprofit, nonpartisan organization which relies primarily on the support of foundations, religious groups, corporations, individuals and others to continue its work on behalf of the disadvantaged.

FOREWORD

In 1972, Congress found, in the Child Nutrition Act, that "substantial numbers of pregnant, postpartum, and breastfeeding women, infants and young children from families with inadequate income [were] at special risk with respect to their physical and mental health by reason of inadequate nutrition or health care or both." A program was to be developed "to prevent the occurrence of health problems and improve the health status of these persons" [emphasis added] by providing them with supplemental foods and nutrition education. Thus, Congress had a dual purpose in mind in setting up the WIC Program -- both preventive for those at risk and remedial for those already afflicted with medical problems.

Since that time, the resulting Special Supplemental Food Program for Women, Infants and Children (WIC) has grown to serve 3.9 million women, infants and children as of February 1989. However, when this is compared to the estimated number of individuals who are eligible for the program, the participation rate comes to about half of those eligible for WIC. According to the most recent U.S. Department of Agriculture estimates (1984), substantial numbers of eligible women and children, in particular, are not participating in WIC. As long as the percentage served remains low for any category of eligible persons who wish to participate, the full promise of the WIC Program will not be fulfilled.

Congress has consistently voted for increases in funding for the WIC Program. In addition, a number of states have increased the funds available in the WIC Program by contracting to buy infant formula at reduced rates and by passing state legislation that supplements federal WIC funding. However, Congress has not yet provided sufficient funding to serve all of the people who are eligible for and in need of WIC benefits, in spite of significant growth in the 1980s in the numbers of women and children living in poverty.* Unfortunately, there are no alternative programs in the social "safety net" that meet all the nutrition and health needs that WIC does. The Food Stamp Program does serve the WIC-eligible population but is not designed to meet the special nutrition needs of at-risk pregnant women, new mothers, infants and young children.

The U.S. Department of Agriculture has suggested in testimony before Congress that the large sums of money made available to states through infant formula rebates have eliminated the need for significantly increased federal funding for WIC. According to 1988 and 1989 surveys of WIC Directors carried out by FRAC, infant formula rebates have indeed allowed many states to serve more women, infants and children. However, several million people who are fully eligible for WIC still remain unserved, and the vast majority (84 percent) of WIC Directors continue to cite inadequate funding as a major problem in their states. Furthermore, as the initial impact of the rebates wears off, inadequate funding will probably become an increasing problem. WIC's financial

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*According to the most recent poverty data, 23 percent of children under age six in the United States were poor in 1987.

inability to reach all those who are eligible is particularly disturbing because we know that WIC can save lives and improve women's and children's health. A national evaluation of the program, funded by the Department of Agriculture and reported in 1986, demonstrated that participation in WIC decreased late fetal deaths, neonatal mortality rates and preterm deliveries; increased birthweight; and improved the diets of low-income women, infants, and children, among other findings.

Feeding the Other Half: Mothers and Children Left Out of WIC reviews the available information on: (1) the impact of participation in WIC on health and nutritional status; (2) program growth; (3) who participates in WIC; (4) who is unserved and why; (5) the consequences of not serving those in need; and (6) whether unserved WIC participants are served elsewhere. (This report also includes findings of a FRAC survey of State WIC Directors, described on page vii.) Based on this review policy decisions are made. The major recommendation is that, within as short a time as is logistically possible, probably over the next four to five years, federal spending should be increased by steady increments (about five to seven percent over inflation) in order to serve virtually all who are eligible and wish to participate.

WIC's proven track record, and the great need for its health and nutrition services nationwide, argue strongly for significantly increased funding levels for the program, even in this time of close attention to deficit reduction efforts. If WIC were adequately funded, it would truly be a preventive program for all low-income women, infants and children at nutritional risk, as Congress originally intended. The Ford Foundation, in its recent report, *The Common Good: Social Welfare and the American Future*, stated, "The payoff of WIC services seems clear, but our commitment to the program has been feeble...we recommend full funding for the WIC Program as an entitlement for nutritionally at risk women and children with incomes of up to 185 percent of the federal poverty line." By not fully funding WIC, we risk paying a higher price later -- in medical costs, in lost productivity and creativity, and in fewer infants reaching their first birthday. Therefore, FRAC supports the expansion of WIC to all who are eligible over the next four to five years.

FRAC WIC SURVEY -- 1988 AND 1989

To learn more about local and state efforts to expand and improve WIC, in 1988 the Food Research and Action Center surveyed state WIC Directors, Nutrition Coordinators and selected statewide WIC advocates in all 50 states and the District of Columbia. Questions were asked about common barriers to participation and successful ways to overcome them; cost-saving methods; innovative outreach techniques; and statewide WIC organizations. Program management issues were examined, such as waiting lists, certification periods, and coordination with other social services. The questionnaire was completed and returned by WIC Directors in 43 states and the District of Columbia. WIC Nutrition Coordinators in 40 states and the District of Columbia, and WIC advocates in 15 states also responded.

In April 1989, a follow-up telephone survey was conducted to ascertain whether the funding situation in the states had changed significantly since the 1988 survey in large part because of the implementation of infant formula rebates. Forty-two states and the District of Columbia participated in the 1989 survey.

Whenever FRAC surveys are mentioned in the text, these are the surveys to which the report is referring.

FEEDING THE OTHER HALF:
MOTHERS AND CHILDREN LEFT OUT OF WIC

EXECUTIVE SUMMARY

WIC: COST-EFFECTIVE PREVENTIVE NUTRITION

The Special Supplemental Food Program for Women, Infants, and Children, commonly known as WIC, is a cost-effective nutrition intervention program with demonstrated success in improving the health and nutritional status of women, infants and children. WIC provides supplemental foods and nutrition education to low-income women, infants and children who have been determined by medical authorities to be at nutritional risk. According to law, the program should serve as "an adjunct to good health care, during critical times of growth and development, to prevent the occurrence of health problems and improve the health status of these persons."

Many national, state and local studies have demonstrated that WIC is successful both in bringing low-income women, infants and children into health care and improving their health and nutritional status. These studies have found that WIC leads to: increases in early enrollment in prenatal health care; decreases in the rate of preterm deliveries; increases in birthweight; reduced late fetal death rates and neonatal mortality rates; improvements in nutritional intake in women, infants and children; decreased incidence of anemia; improved cognitive development in young children; and improved health care and immunization of young children. Studies have also documented savings in medical costs as a result of not having to hospitalize babies because of low birthweight.

PROGRAM GROWTH AND PARTICIPATION

In 1984, the most recent year for which the U.S. Department of Agriculture has data on WIC eligibility, 7.45 million women, infants and children were estimated to be both income eligible and at nutritional risk -- making them fully eligible for WIC. Currently, only about half of those eligible are being served by the WIC Program. The program's failure to serve all who qualify is primarily the result of insufficient funding.

WIC is not an entitlement program. It must operate within the appropriation it receives from Congress each fiscal year. In fiscal year 1988, the federal appropriation of $1.802 billion provided supplemental foods and nutrition education to an average of 3.6 million participants per month. The funding level for fiscal year 1989, $1.929 billion, serves 3.9 million participants per month, according to the most recent data available (fiscal year 1989 year-to-date figures through February).

THE UNSERVED

The majority of children (ages one to five years) eligible for WIC are not being served. According to the most recent estimates (based on the 1980 census updated to 1984, nutrition surveys carried out from 1976 to 1980, and fiscal year 1989 year-to-date participation levels through February), only about 38 percent of those children eligible for WIC are participating in the program. In fact, according to a 1989 FRAC survey of State WIC Directors, almost one-fourth (23 percent) of the 43 states responding had developed cut-off points for the age or priority level (kind of risk) of children that could be served by WIC or were not serving any children in priority V (i.e., children with inadequate diets). In other words, children above certain ages, or children who had inadequate diets (but did not have medical conditions, such as anemia or poor growth), could not participate in the program.

WIC serves about 59 percent of eligible women. This includes pregnant (about 78 percent of eligibles served), breastfeeding (approximately 29 percent of eligibles served) and postpartum non-breastfeeding (an estimated 53 percent of eligibles served) women, based on the aforementioned estimates of eligibles served, participation levels in fiscal year 1989, and the most recent breakdown of categories of women served (March 1988). While nearly all the states surveyed by FRAC provided participating breastfeeding women with up to 12 months of WIC benefits, almost one-third (30 percent) of the 43 states responding did not provide full WIC benefits to non-breastfeeding postpartum mothers. They served these women only if they were adolescents or served all ages but only up to six weeks (instead of the six months allowed by WIC regulations) or did not serve non-breastfeeding postpartum women at all.

WIC appears to be approaching saturation in reaching fully eligible infants. However, given the inherent limitations of the methodology used in determining eligibility estimates, there still may be a significant number of eligible infants who are not being served by the program.

WHY ARE SOME PEOPLE SERVED AND OTHERS NOT?

In order to assure that persons at greatest risk receive WIC benefits first, potential recipients are ranked by a "priority system." The prioritization by risk serves pregnant women and infants before children, and those with medical risks before those with inadequate diets. Federal regulatory funding formulae issued in 1987 give incentives to states that serve the highest proportion of participants in the top priority. While there is no debate that reaching those at highest risk is essential, especially when program funding is insufficient to reach all those who are eligible, the increased federal emphasis on this system may obscure one of the major missions of the WIC Program: to prevent nutritional problems among highly vulnerable women, infants and children. Because of insufficient funding levels, many of these at-risk individuals are not served.

THE CONSEQUENCES OF NOT SERVING THOSE IN NEED

There are harmful consequences of not providing WIC benefits to eligible women, infants and children.

Infants and preschoolers are going through a period of rapid growth and intellectual and social development. Poor nutritional status can lead to increased illness and decreased ability to learn. WIC has been shown to significantly improve the nutrient intake of infants and children age one to five years. According to the Centers for Disease Control, iron deficiency anemia, a specific kind of undernutrition, has decreased among low-income preschool children between 1975 and 1985, due in part to the WIC Program. Also, according to the U.S. Department of Agriculture's national evaluation of the WIC Program, children who receive WIC benefits after their first birthday have significantly better memory of numbers than do children who receive no WIC benefits, and children enrolled in WIC are more likely to have a regular source of medical care and be better immunized.

WIC has a positive impact on the outcome of pregnancy -- fewer preterm deliveries; fewer babies born at low birthweight; reduced late fetal and neonatal death rates; and increased head circumferences. This is not surprising, because the growth rate of a fetus is more rapid than at any other time of life, and this growth depends on nutrients from the mother's food intake. Low birthweight, one of the most important indicators of whether newborns will grow and develop normally, is related to the nutritional status of the pregnant woman.

WIC supplemental foods and nutrition education make an important difference in the diets of new mothers. Breastfeeding requires additional calories from high quality nutritious foods because of the nutritional costs of producing breast milk. Moreover, whether a woman breastfeeds or not, her preconceptional nutritional status is an important determinant of the health of her next born. What a woman eats during the interpregnancy period can prepare her for future pregnancies by replenishing nutrient stores that may have been depleted during the previous pregnancy. This is particularly important because many WIC mothers entered their previous pregnancies with a marginal nutritional status.

ARE THOSE UNSERVED BY WIC SERVED ELSEWHERE?

According to FRAC's 1989 survey, many of the individuals put on waiting lists for WIC are referred to other programs such as food pantries, the Food Stamp Program, or the Expanded Food and Nutrition Education Program. However, none of the other programs available to low-income women and children are adequate substitutes for WIC. WIC offers (1) supplemental foods which provide the nutrients that low-income pregnant and postpartum women, infants and children most need; (2) nutrition education; (3) nutrition assessment; and (4) referral to health care. In addition, little is known at the state level about the characteristics of people who are eligible for WIC but not served, or about whether these people receive other social services.

Lack of information or misinformation about WIC was reported as a barrier to program participation in nearly two-thirds of the states surveyed by FRAC in April 1989. Some of those eligible for WIC simply do not know that the program exists. These individuals may be at very great risk because they are out of touch with most health and social service programs. Women living near the poverty line may know about the WIC Program, but not know they are eligible.

Also, there are a number of other barriers to participation in the WIC Program. Solutions to these barriers involve little or no cost, such as coordinating WIC and Medicaid eligibility requirements, making WIC more accessible to working women, and setting reasonable limits on the age of medical data used to determine risk.

RECOMMENDATIONS FOR INCREASING PARTICIPATION IN THE WIC PROGRAM

The preventive nature of the WIC Program can be fully realized if WIC benefits are made available to all those who are eligible. This kind of expansion of the program is supported by many members of Congress, corporate executives, university presidents, education and labor leaders, the Ford Foundation, and former Presidents Ford and Carter.

While various strategies can be employed to increase participation, WIC is unlikely to reach its full potential without a significant increase in the federal commitment to funding the program. In some states, the legislature has appropriated supplemental funds for WIC. In addition, the use of cost-saving methods such as infant formula rebates, and, to a lesser extent, increases in breastfeeding rates among WIC mothers, will also make funds available for expanding the WIC Program. However, the need is so great that neither state supplemental funding nor infant formula rebates can be expected to fill the gap without increased federal appropriations.

In recent years, WIC funding increases have made modest gains in reaching the unserved population. Because of competing funding needs, appropriations for WIC have fallen short of Congressional Budget Resolution spending recommendations. WIC should be placed on par with other low-income programs that serve all individuals who are eligible, such as AFDC, and the School Lunch Program. If WIC is to come close to serving all of the eligible women, infants and children who choose to participate, within as short a time frame as is logistically possible, funding increases of about five to seven percent over inflation will have to be appropriated in each of the next four to five years.

I. WIC: COST-EFFECTIVE PREVENTIVE NUTRITION

A. THE WIC PROGRAM: PREVENTIVE NUTRITION

The Special Supplemental Food Program for Women, Infants, and Children (WIC) is one of the nation's most popular and successful nutrition intervention programs. WIC was developed as a targeted program to safeguard the health and nutritional well-being of our nation's women, infants and children by serving as an adjunct to good health care during critical periods of growth and development. The Congress intended that the program both "prevent the occurrence of health problems" and "improve the health status" of low-income women, infants and children.

WIC is operated primarily by local health department clinics and provides supplemental foods*, nutrition education, nutrition assessments and referral and access to health care in order to reduce the incidence of nutrition-related health problems of pregnancy, infancy and early childhood. WIC was created by Public Law 92-433 in 1972. In 1974, 205,000 participants received WIC services. By February 1989, WIC had grown to serve 3.9 million low-income women, infants and children at nutritional risk.

B. REQUIREMENTS FOR PARTICIPATION IN WIC

In order to participate in the WIC Program, an applicant must meet three basic eligibility criteria: categorical, income and nutritional risk. These criteria are outlined below.

1. Categorical Eligibility

Participants must be pregnant women, non-breastfeeding new mothers (up to six months after delivery), breastfeeding women (up to one year after delivery), infants (up to age one) or children (up to their fifth birthday).

2. Income Eligibility

States set their own income eligibility guidelines within limits set by the federal government. The maximum income limit is 185 percent of the U.S. Poverty Income Guideline, and no income guideline may be set below 100 percent of poverty. (See Table 1.) The majority of the states use 185 percent as their income eligibility standard.

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*These foods include infant formula, infant cereal, milk, juice, cereal, eggs, cheese, legumes and peanut butter.

TABLE 1

National Minimum and Maximum WIC Income Limits[1]

100% and 185% of the Annual Federal Poverty Income Guidelines
(Income Eligibility Guidelines for the Special Supplemental
Food Program for Women, Infants and Children)

Effective July 1, 1989 - June 30, 1990
for the Contiguous States and U.S. Territories

Family Size	100% of Poverty	185% of Poverty
1	$ 5,980	$11,063
2	$ 8,020	$14,837
3	$10,060	$18,611
4	$12,100	$22,385
5	$14,140	$26,159
6	$16,180	$29,933
7	$18,220	$33,707
8	$20,260	$37,481
For each additional family member add...	$ 2,040	$ 3,774

[1]54 Fed. Reg., at pg. 20168, May 10, 1989.

3. Nutritional Risk Eligibility

The WIC Program is unique in that it is designed to serve those who are not only low-income, but also at nutritional risk. Two major types of nutritional risk are generally recognized by the program: medically-based risk and diet-based risk. A participant's risk must be evaluated and certified by a "competent professional authority" (e.g., a physician, nutritionist, dietitian, registered nurse, physician's assistant, etc.)

Medically-based nutritional risk includes abnormal weight gain during pregnancy; teen pregnancy, or history of complications during pregnancy; growth problems in infants and children such as stunting, underweight, or obesity; and iron-deficiency anemia in all groups.

Diet-based nutritional risk includes undernutrition or inadequate dietary patterns. Food allergies, and other diet-based factors that may negatively influence the participant's nutritional status, are also considered nutritional risks.

In 1984, the most recent year for which U.S. Department of Agriculture has data on eligibility, 9.6 million persons were estimated to be income-eligible for WIC. The vast majority (about 77 percent or 7.45 million) of these people were also estimated to be at nutritional risk -- making them fully eligible for WIC.[2] Although these numbers are the best we currently have, they must be used with care because they are estimates based on 1980 census data updated to 1984 and national health and dietary survey data from 1976 to 1980.

C. WIC: A SUCCESS STORY

Many national, state and local studies have demonstrated that WIC is successful in bringing low-income women, infants and children into the health care setting, preventing health problems, and improving health and nutritional status. These studies have found that WIC participation resulted in enhanced participation in prenatal care[3,4]; increases in birth weight[5,6,7,8,9]; and improvements in health and nutritional status such as decreased

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[2]U.S. Department of Agriculture: "Estimation of Eligibility for the WIC Program, Report of the WIC Eligibility Study," Food and Nutrition Service, July 1987.

[3]Kotelchuck, M., et al., Massachusetts Department of Health, (1980) "WIC Participation and Pregnancy Outcomes," *American Journal of Public Health*. 74:1086, 1984.

[4]Rush, D., et al., "The National WIC Evaluation: Evaluation of the Special Supplemental Food Program for Women, Infants and Children," *American Journal of Clinical Nutrition*. Supplement Volume 48, Number 2, August 1988.

[5]Edozien, J., Switzer, B., and Bryan, R. "Medical Evaluation of the Special Supplemental Food Program for Women, Infants and Children," *American Journal of Clinical Nutrition*. 32:677, 1979.

[6]Kotelchuck, et al, 1984.

incidence of anemia, and improved weight gain during pregnancy.[10],[11],[12]

The most comprehensive evaluation of the WIC Program, "The National WIC Evaluation" (1986), a five year study by the federal government, found significant, positive effects of receiving WIC benefits.[13] Many of the earlier research findings on the benefits of WIC were confirmed by this study. Some of the most important findings of the National WIC Evaluation were:

- Improved health care for pregnant women -- A significant increase in early enrollment in prenatal care and a significant reduction in the proportion of women with inadequate numbers of visits for prenatal care. (The researchers state, "It is likely that the WIC Program served as an inducement for early registration..." and "Once enrolled in the program enrollees used prenatal health care more frequently.")

- Improved weight gain among pregnant women

- Improved pregnancy outcome -- Increased length of gestation and significant decreases in the rate of preterm delivery; significantly reduced late fetal deaths; significant increases in birthweight; reduced neonatal mortality rates; larger head circumferences at birth; and significantly better vocabulary scores when WIC benefits were received in utero (during their mothers' pregnancy).

- Improved nutritional intake for infants -- Significantly increased intakes of iron and vitamin C.

- Improved nutritional intake for children -- Significantly increased intakes of iron, vitamin C, thiamin, niacin and vitamin B6.

- Improved health care for children -- Children enrolled in WIC were more likely

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[7]Kennedy, E., et al., "Evaluation of the Effect of WIC Supplemental Feeding on Birth Weight," *Journal of the American Dietetic Association*. 80:220, 1982.

[8]Stockbauer, J., "Evaluation of the Prenatal Participation Component of the Missouri WIC Program," *Journal of the American Dietetic Association*. 86(1)" 61, 1986.

[9]Schramm, W. "WIC Prenatal Participation and Its Relationship to Medicaid Costs," *American Journal of Public Health*. 75(8):851, 1985.

[10]Edozien, et al, 1979.

[11]Centers for Disease Control, Public Health Service, "CDC Analysis of Nutrition Indices for WIC Participants," Nutrition Surveillance, U.S. Department of Health, Education, and Welfare, Washington, D.C., 1977.

[12]Kennedy, et al, 1982.

[13]Rush, et al, 1988.

to have a regular source of medical care and were better immunized than non-WIC children.

- Improved cognitive development among children -- Children who began receiving WIC benefits after their first birthday had significantly better digit (number) memory than did children who received no WIC benefits at all.

- Improved nutritional intake among pregnant women -- Significantly increased intakes of protein, iron, calcium, vitamin C, calories, magnesium, phosphorus, thiamin, riboflavin, niacin, vitamin B6 and vitamin B12.

D. COST-EFFECTIVE PREVENTION

Studies which have examined the cost-effectiveness of WIC have focused primarily on the costs of providing WIC benefits to pregnant women versus the subsequent savings in medical costs as a result of not having to hospitalize babies because of low birthweight. One study, conducted in the state of Missouri, found that for every dollar spent on WIC prenatal benefits, 49 cents in Medicaid costs were saved in the first 45 days following birth.[14] Another study conducted at Harvard University found that for every one dollar spent on the prenatal component of WIC, three dollars in hospitalization costs during the first 30 days of life were saved as a result of improved birth outcomes.[15]

It would be desirable to know the extent of cost savings achieved through the other improvements in health status that are associated with WIC participation (for example, through the prevention of anemia and its potential for harming the health and cognitive development of children), but little data exist to assess these savings.

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[14]Schramm, Wayne F., "Prenatal Participation in WIC Related to Medicaid Costs for Missouri Newborns: 1982 Update," *Public Health Reports*, Vol. 101 (6): 607, Nov. - Dec. 1986.

[15]Kennedy, E.T., et al., "Cost/Benefit and Cost/Effectiveness of WIC," Unpublished paper. Testimony before the Select Committee on Children, Youth, and Families, U.S. House of Representatives, June 1983.

II. PROGRAM GROWTH AND PARTICIPATION

GROWTH OF THE WIC PROGRAM

Funding for the WIC Program has increased significantly since it was first authorized in 1972. Each year since 1982, Congress has appropriated higher funding levels than the previous year in spite of consistently low budget requests by the Administration. (See Appendix A.)

The WIC Program, however, remains limited by its funding status. WIC is not an entitlement program. It is a "discretionary" program which must operate within the annual funding levels appropriated by Congress.

Increased federal funding levels have supported increased participation. The WIC Program has grown from a pilot program serving 205,000 individuals in fiscal year 1974 to serving 3.9 million women, infants and children in fiscal year 1989, according to fiscal year 1989 year-to-date participation levels through February. The figures in Table 2 demonstrate the rapid growth of participation in the WIC Program between 1977 and 1988. Despite almost constant growth in program funding, the funding levels appropriated have never come close to serving all of those eligible and wishing to participate.

Almost half of WIC participants are children, almost a third are infants, and nearly a quarter are women. According to a 1986 U.S. Department of Agriculture "Study of WIC Participant and Program Characteristics," the majority of WIC participants were white, less than one-third were black, and about 17 percent were Hispanic. About 85 percent had incomes below 130 percent of the federal poverty level.[16]

[16]U.S. Department of Agriculture, "Study of WIC Program and Participant Characteristics," April 1986.

TABLE 2

Participation in the WIC Program by Women, Infants and Children

FY 1977 to FY 1988
(average monthly caseload in thousands)[17],[18]

Fiscal Year	Women[19]	Infants[20]	Children[21]	Total[22]
1977	165	213	471	848
1978	240	308	633	1,181
1979	321	389	782	1,483
1980	411	507	995	1,913
1981	446	585	1,088	2,119
1982	478	623	1,088	2,189
1983	542	730	1,265	2,537
1984	657	825	1,563	3,045
1985	665	874	1,600	3,138
1986	714	947	1,654	3,314
1987[23]	750	1,019	1,655	3,425
1988[24]	819	1,096	1,681	3,597

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[17]While participation figures for all categories have increased every year since 1977, only about half of those eligible for WIC are participating.

[18]Source for FY 1977 through FY 1986: U.S. House of Representatives, Committee on Ways and Means, Committee Print, March 6, 1987.

[19]This includes pregnant, postpartum and breastfeeding women.

[20]This includes infants from birth to one year old.

[21]This includes children from age one to their fifth birthday. Although the number of children is increasing, the percentage of eligible children served is lower than the percentage of eligible women and infants served.

[22]Columns may not equal total due to rounding.

[23]Source: "WIC Program: State Agency Participation and Expenditure Report," U.S. Department of Agriculture, Food and Nutrition Service, September 1987.

[24]Source: "WIC Program: State Agency Participation and Expenditure Report," U.S. Department of Agriculture, Food and Nutrition Service, September 1988.

III. THE UNSERVED

A. THE ELIGIBLE AND UNSERVED

In 1987, the USDA, in its study "Estimation of Eligibility for the WIC Program," made estimates of the total number of people eligible for WIC Program benefits based on all three eligibility criteria: categorical, income and nutritional risk.[25] Previous studies had calculated potential eligibles based on the income and categorical risk criteria only.

The authors of the WIC eligibility study on which these estimates are based, caution:

> "As with any estimates, the figures developed in the WIC Eligibility Study should be recognized as limited to some extent in accuracy and reliability. This is due primarily to limitations in the existing data sources as bases for making this particular estimation. Perhaps most important, neither of the national sample surveys used in estimating frequency of nutritional risk among lower-income women, infants, and children [conducted in 1976 through 1980] was designed to sample directly the WIC-eligible population as such...Nonetheless, these are the best estimates of WIC eligibility that are available at this time."

In 1984, according to this USDA study, there were 7.45 million individuals fully eligible for WIC benefits in the 50 states and the District of Columbia. When this figure is compared to the most recent data available on average monthly participation (fiscal year 1989 year-to-date participation levels through February) -- 3.9 million -- it reveals that about half of those estimated to be fully eligible were served.

B. MOST ELIGIBLE CHILDREN DO NOT RECEIVE WIC SERVICES

Table 3 shows that the majority of children (ages one to five years) who are eligible for WIC are not being served, according to 1984 estimates of total eligible children and fiscal year 1989 year-to-date participation levels through February. Just over one-third (about 38 percent) of the children estimated to be fully eligible for WIC are participating, according to these estimates. Moreover, according to a report by the Center on Budget and Policy Priorities (CBPP), "while the size of the WIC Program increased substantially between fiscal years 1981 and 1987, the proportion of the national WIC caseload consisting of children (the largest group of potentially eligible participants) has not increased at all. In fact, in recent years, the proportion of participants who are children has actually decreased somewhat." According to CBPP,

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[25] U.S. Department of Agriculture, "Estimation of Eligibility for the WIC Program," July 1987.

this national trend between 1981 and 1987 in targeting WIC benefits toward women and infants is mirrored in 31 of the 50 state agencies.[26]

According to FRAC's survey, 23 percent of the 43 states responding had developed cut-off points for the age or priority level (kind of risk) of children that could be served by the WIC Program or were not serving any children in Priority V. In other words, children above a certain age or children who had diet-based risks (but did not have medical conditions such as anemia or poor growth) could not participate in the program.

TABLE 3

Estimated Number of Women and Children Eligible For and Participating in the WIC Program, Based on FY 1989 Year-to-Date Participation Levels Through February[27]

	Fully Eligible (in millions)	Participating in WIC	Program Coverage (%)
Women	1.53	0.90	59%
Children (1-5 years)	4.71	1.80	38%

[26]Summer, Laura, *Targeting Benefits in the WIC Program*, Center on Budget and Policy Priorities, Washington, D.C., 1988.

[27]Sources: U.S. Department of Agriculture, Estimation of Eligibility Study, 1987 and WIC Program State Agency Participation and Expenditure Report, FY 1989, February 1989.

C. WOMEN AND INFANTS UNSERVED IN MANY STATES

According to fiscal year 1989 year-to-date participation figures through February and the 1984 estimates of total eligibles, WIC serves about 59 percent of eligible women. A more detailed look at program coverage reveals a relatively high coverage of eligible pregnant women (about 78 percent) and a low coverage of non-breastfeeding postpartum and breast-feeding women (approximately 53 percent and 29 percent, respectively) (Note: The latter three figures are based on 1984 estimates of eligibility, fiscal year 1989 participation levels, and March 1988 enrollment figures for women, the most recent breakdown available for categories of women.)

While nearly all of the states surveyed by FRAC in 1989 provided participating breastfeeding women with up to 12 months of WIC benefits, 30 percent of the 43 states responding limited participation of non-breastfeeding postpartum mothers in some way. They served these postpartum women only if they were adolescents or served all ages of postpartum women but only up to six weeks or did not serve postpartum non-breastfeeding women at all. (The regulations allow postpartum women to be served up to six months after the birth of their children if they are low-income and determined to be at nutritional risk.)

If the same 1984 estimates of eligibility are applied to current infant participation levels in WIC, it appears that the program is approaching saturation in reaching fully eligible infants. However, given the inherent limitations of the methodology used in determining the eligibility estimates, this cannot be ascertained with assurance. While there is no doubt that a large percentage of eligible infants is being served, a very significant and important accomplishment for the WIC Program, there still may be a significant number of eligible infants who are not participating in the program.

IV. WHY ARE SOME PEOPLE SERVED AND OTHERS NOT?

A. THE WIC PRIORITY SYSTEM

In order to assure that persons at greatest nutritional risk receive WIC benefits, potential recipients are ranked by a "priority system." In general, the prioritization by risk serves pregnant women and infants before children, and those with medical risks before those with dietary risks. (Table 4 lists the priority assignments used in the WIC Program. This list was first developed in 1977 as part of the WIC Program regulations and revised in 1985.)

B. THE PUSH TO SERVE THE HIGHEST PRIORITIES

According to the regulations governing the program, WIC clinics need not use the priority system to determine whom of those applying they serve first unless clinics have reached the highest number they can serve, referred to as "at caseload." However, whether or not a clinic is at caseload, the current focus nationwide is on those in the highest priority categories.

This focus has been intensified by federal regulatory funding formulae issued in 1987 that give incentives to states with caseloads containing high percentages of participants in the top priority. While there is no debate that reaching those at highest risk is essential, especially when program funding is insufficient to reach all those who are eligible, the increased federal emphasis on this may obscure one of the major missions of the WIC Program: to prevent nutritional problems among highly vulnerable women, infants and children.

The effective targeting of benefits to the highest risk categories has been used by some as a basis to oppose funding increases for WIC to serve the remaining eligible populations. The practical result is a significant modification of the original purpose of the WIC Program -- "to prevent the occurrence of health problems and improve the health status of ...pregnant, postpartum, and breastfeeding women, infants and young children from families with an inadequate income...at special risk with respect to their physical and mental health by reason of inadequate nutrition or health care or both" (emphasis added). Instead, the program can come to be seen more as an acute care program for pregnant women and infants.

This new emphasis may create the impression that those falling into lower priorities are not in need. In reality, people who fall into the lower priorities are, by definition, fully eligible for WIC and in need. Yet, several million women, infants and children currently have little chance of being served by WIC. This is especially true for those who have inadequate diets, but are not yet suffering from medical conditions, such as anemia or poor growth.

TABLE 4

WIC Priority Assignment System[28]

7 C.F.R. 246.7(d)(4)

(I) Pregnant women, breast-feeding women and infants at nutritional risk as demonstrated by blood tests, abnormal growth, or other nutritional or medical conditions.

(II) Infants up to six months of age born to program participants who participated during pregnancy, and infants up to six months of age born to women who were not program participants during pregnancy but who would have been eligible as defined in I above.

(III) Children up to age five at nutritional risk as defined in I above.

(IV) Pregnant women, breastfeeding women, and infants at nutritional risk because of inadequate dietary pattern.

(V) Children at nutritional risk because of inadequate dietary pattern.

(VI) Postpartum women at nutritional risk.

(VII) Previously certified participants who might regress in nutritional status without continued provision of supplemental foods. This category exists as a state agency option.

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[28]Note: The state may set income or other sub-priority levels within any of these seven priority levels. The state may also expand Priorities III, IV, or V to include high-risk, postpartum women.

C. WAITING FOR WIC: WAITING LISTS FOR THE WIC PROGRAM

When a local WIC program has reached its maximum caseload, new applicants who cannot be served will often be placed on a waiting list. Because it was not feasible to collect information on waiting lists from every local WIC clinic in the country, an alternative method was used to obtain a "snapshot" of WIC waiting lists: FRAC asked state agencies what they knew about waiting lists in their states. Of those responding that they had waiting lists in their states (28 percent), most reported that these lists included primarily postpartum women and children.

Comments by the WIC Directors concerning waiting lists revealed the difficulties brought on by the insufficient funding of the WIC Program. One state agency was able to "control (the) waiting list problem by using age restrictions [i.e., limiting the children coming into the program to those below a certain age] --otherwise, the waiting lists got to be longer than the list of participants." Another WIC Director reported that her state does not "foresee serving non-teen postpartum women or children within six months or even a year. So on a statewide basis, we don't keep waiting lists because we don't have the manpower [to serve them]." Other states reported: "Postpartum women in our state are on a waiting list indefinitely"; "Postpartum women in our state may wait as long as four to five months or may never be served"; "We've stopped keeping waiting lists because there are too many people who can't be served"; and "Waits are long in rural areas where clinics are only open once a month."

V. THE CONSEQUENCES OF NOT SERVING THOSE IN NEED

Congress intended that WIC both prevent health problems and improve the health status of low-income women, infants and children. Yet WIC continues to miss many opportunities to prevent health problems before they start because it lacks the funding to make the program available to all eligible individuals.

A. NUTRITION, HEALTH AND LEARNING: IMPACTS ON CHILDREN

As mentioned earlier in this report, WIC has been shown to significantly improve the nutrient intake of infants (vitamin C and iron) and children age one to five years (iron, vitamin C, thiamin, niacin, and vitamin B6). Also, children who receive WIC benefits after their first birthday had significantly better digit (number) memory than did children who received no WIC benefits at all. Moreover, children enrolled in WIC were more likely to have a regular source of medical care and were better immunized than non-WIC children.[29]

Infants and preschoolers are going through a period of rapid growth and intellectual and social development. Their nutritional status and the health care they receive can have a major impact on their ability to function as happy, healthy children.

Undernutrition can lead to growth retardation, increased risk of infections and more frequent and severe illnesses.[30] The United States still has a problem with stunting and wasting in children as a result of inadequate nutrition. According to the U.S. Public Health Service, the Surgeon General's 1990 goal of eliminating growth retardation of infants and children caused by inadequate diets cannot be met, because there are still significant numbers of low-income children whose growth is retarded.[31]

In addition, children who are undernourished are less physically active and do not explore their environment the way their better nourished peers do. They are less attentive, less independent, less curious, and less interested in their environment. They are more apathetic, irritable, and tired. They are more anxious, and less responsive socially, and they cannot concentrate as well. Thus, their mental performance and motor abilities can suffer.[32]

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[29] Rush, et al., 1988.

[30] National Education Association, *The Relationship Between Nutrition and Learning: A School Employee's Guide to Research and Action*, 1989.

[31] U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, *The 1990 Health Objectives for the Nation: A Mid Course Review*, Washington, D.C., U.S. Government Printing Office, November 1986.

[32] National Education Association, 1989.

Iron deficiency is a specific kind of undernutrition. It is one of the most prevalent nutritional problems in the U.S., especially among young children. This condition affects children at all income levels, but its incidence is higher among poor children. Iron deficiency anemia affects a child's behavior and ability to learn in much the same way as undernutrition. According to recent research, even mild cases of anemia can significantly influence the behavior of young children and adolescents. These behavioral effects interfere with the child's ability to learn and interact in a positive manner with his or her educational environment. The negative behavioral changes seen in anemic children include shortened attention span, irritability, fatigue, and a decreased ability to concentrate. As a result, anemic children do poorly on vocabulary, reading, mathematical, problem-solving, and psychological tests. Furthermore, the development of their motor abilities are delayed and their memories are impaired.[33]

Data collected by the Centers for Disease Control (CDC) show that the rate of iron-deficiency anemia among low-income children dropped from 7.8 percent in 1975 to 2.9 percent in 1985. CDC attributes this sharp drop in anemia in part to public nutrition programs, including WIC.[34]

An important additional benefit of healthy iron status for low-income children is that it can reduce the chances that children will develop lead poisoning, since iron displaces lead. Because low-income children are more likely to suffer from iron deficiency, as well as more likely to be exposed to lead in the environments in which many of them live, their iron status becomes particularly important. Even small amounts of lead in the body can have negative cognitive and behavioral effects.[35]

The failure of the WIC Program to serve most of the eligible children between one and five years old means that many children in need are realizing the improved nutritional intake, reduced incidence of anemia, improved cognitive development, better immunization and more regular source of health care that WIC provides. One of the less frequently mentioned findings of "The National WIC Evaluation" highlights even more starkly the need to expand the program to more eligible children. The researchers report that "age-eligible children who were not retained in the WIC Program [once on, but now off the program] appeared to be as vulnerable to nutritional risk by all the indices of need available in this study as were children who were current WIC recipients." The study showed that children lost to the program or not recertified were thinner, shorter, as poor, and were more likely to live in isolated two-person households or in large households than children remaining in the program.[36]

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[33]Ibid.

[34]Centers for Disease Control, "Declining Anemia Prevalence Among Children Enrolled in Public Nutrition and Health Programs – Selected States, 1975-1985," *Morbidity and Mortality Weekly Report*, Vol. 35, No. 36, September 12, 1986.

[35]National Education Association, 1989.

[36]Rush, et al., 1988.

B. BEFORE THEY ARE BORN: NUTRITION DURING PREGNANCY

WIC has been shown to: significantly increase early enrollment in prenatal care; increase the length of gestation; significantly decrease the rate of preterm delivery; significantly increase birthweight, significantly reduce late fetal death rates and reduce neonatal mortality rates; increase head circumferences of newborns; increase the vocabulary scores of children whose mothers received WIC benefits in utero; and significantly increase women's nutritional intake.[37]

A child's health and intellectual abilities begin with pregnancy. The growth rate of the fetus is more rapid than at any other time of life, and this growth depends on nutrients from the mother's food intake. Pregnant women require a high quality diet, and an additional 300 calories per day that come from nutritionally rich foods.[38]

Low birthweight is one of the most important indicators of whether newborn babies will grow and develop normally. According to a recent review of the scientific literature on this topic by the Institute of Medicine at the National Academy of Sciences, low birthweight is related both to poor nutritional status of the mother before she becomes pregnant and poor weight gain resulting from an inadequate diet during pregnancy. Babies with low birthweights are at greater risk of being mentally retarded or of suffering visual and hearing impairments. They are also more likely to have behavior and learning problems later in life.[39]

C. HELPING NEW MOTHERS: NUTRITIONAL NEEDS OF BREAST-FEEDING AND POSTPARTUM WOMEN

Breastfeeding women require high quality diets and an additional 500 calories a day from nutritionally rich foods.[40] Moreover, whether a woman breastfeeds or not, her preconceptional nutritional status is an important determinant of the health of her next born. What a woman eats during the interpregnancy period can prepare her for future pregnancies by replenishing nutrient stores that were depleted during the previous pregnancy. This is particularly important because many WIC mothers entered their previous pregnancies with a marginal nutritional status. In fact, research on the effect of receiving WIC benefits after pregnancy found that women who received benefits for five to seven months following their first birth, gave birth to second infants who were

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[37] Ibid.

[38] National Academy of Sciences, *Recommended Dietary Allowances, Revised Edition, 1980*. National Academy Press, Washington, D.C., 1980.

[39] Institute of Medicine, National Academy of Sciences. "Preventing Low Birthweight. A Summary." National Academy Press, Washington, D.C., 1985.

[40] National Academy of Sciences, 1980.

significantly heavier and longer than were infants born to women who received WIC for two months or less.[41]

WIC benefits may be particularly important for non-breastfeeding postpartum women because of demographic or social factors. Women who have chosen to bottlefeed are often younger, unmarried, less educated, poorer and without family support.[42] Non-breastfeeding women may also be more likely to conceive their second children earlier. Breastfeeding women usually do not ovulate for four months or more after delivery. Women who bottlefeed their babies begin to ovulate just four to six weeks after delivery.[43] Postpartum WIC participation is also important for another reason: the program is maintaining the mother's contact with the medical care system. Contact with the medical care system is vital for assisting the mother with family planning, future prenatal care and her other health care needs.

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[41]Caan, B., et al., "Benefits Associated with WIC Supplemental Feeding During the Interpregnancy Interval," *American Journal of Clinical Nutrition*, 45:29, 1987.

[42]Scrimshaw, N. and Susan, C.M., "The Cultural Context of Breastfeeding in the United States," Surgeon General's Workshop on Breastfeeding and Human Lactation, June 1984.

[43]Lawrence, Ruth A., "Human Lactation as a Physiologic Process," Surgeon General's Workshop on Breastfeeding and Human Lactation, June 1984.

VI. ARE THOSE UNSERVED BY WIC SERVED ELSEWHERE?

A. WHAT HAPPENS TO THE UNSERVED?

When WIC-eligible individuals are turned away from WIC because of caseload constraints and/or put on waiting lists, they are often referred to other programs and local resources. These may include the Food Stamp Program, Medicaid, the Expanded Food and Nutrition Education Program, the Commodity Supplemental Food Program, and emergency food providers, such as soup kitchens and food pantries.

Most state WIC Directors (72 percent) surveyed by FRAC in 1989 reported that potential WIC recipients placed on the WIC waiting lists were referred to other services. However, little is known at the state level about the characteristics of people who are eligible for WIC but not served, or whether these people receive other social services. Twenty-nine out of 43 (67 percent) WIC Directors responding answered "don't know" to the question, "To your knowledge, are unserved WIC eligibles in your state receiving other Social Services?" Also, 30 of these 43 (70 percent) WIC Directors responded "no" to the question, "Has data been collected in your state that describe the characteristics of the people who are eligible for WIC but not served?" (Typical responses for states in which data were collected on the characteristics of people who were eligible but unserved included: "The largest group of unserved WIC eligibles probably are children"; "There is a problem reaching teens"; "The large urban areas still have a substantial number of unserved individuals"; and "those people with incomes from 125 to 185 percent of the poverty level [tend to be unserved by WIC]."

Even if potential WIC eligibles are referred to and receive other services, they will not be receiving benefits equivalent to those WIC provides. For example, the Food Stamp Program is theoretically designed to provide the resources for a minimally adequate diet. However, with a maximum benefit of 82 cents per person per meal, and an average benefit of 54.5 cents per person per meal, the Food Stamp Program cannot possibly meet the special dietary needs of low-income pregnant and postpartum women, infants and young children at nutritional risk. The extra foods provided by WIC are an important complement to meals purchased with food stamps.

Medicaid helps low-income households pay for health care, but not for food or nutrition education. The Expanded Food and Nutrition Education Program is a relatively small program and only provides nutrition education. Most emergency food providers are not able to provide even a basic diet on a regular basis because of insufficient resources, and certainly cannot be expected to provide the kinds and quantities of supplemental foods needed by low-income women, infants and children at nutritional risk. Thus, although it remains important for all clinics to refer WIC applicants to other existing services, these referrals cannot replace WIC benefits.

Only the Commodity Supplemental Food Program (CSFP) comes close to being a substitute for the WIC Program, and it is not widely available. This program, which provides nutritious commodities to income-eligible individuals, exists in 18 states and the

District of Columbia and serves only 135,500 low-income women, infants and children nationwide.

B. OUTREACH: THE HARD-TO-REACH AND THE NEAR-POOR

An effective program goes beyond serving only those who happen to appear at the WIC clinic. Information and outreach campaigns designed to reach all potential participants and get them to the clinic must be employed.

Lack of information or misinformation about WIC were reported as barriers to participation in nearly two-thirds (63 percent) of the states surveyed. While many states use creative outreach activities, WIC Directors expressed frustration that, nonetheless, many potential WIC recipients did not know about the program or thought they were ineligible.

A number of WIC Directors responding to FRAC's survey said that the individuals most difficult to reach with news of the WIC Program were those who were not in touch with other health and social services. One WIC Director summarized this problem: "Many pregnant women first learn of the WIC Program through their health care providers. In areas of the state which lack prenatal care services for low-income women, the women may not get prenatal care or may enter it late in pregnancy. Consequently, these women may not hear about the program or may learn of it late in their pregnancy."

Word-of-mouth appears to be the most effective outreach mechanism in WIC. However, when misperceptions of program availability arise they are spread quickly by this method. For example, the experience of one WIC Director reflects the comments of many others: "When the WIC priority system is instituted in a clinic, people who would be eligible for services stay away because they hear that 'WIC is closed.'" Another WIC Director points out, "...when waiting lists are instituted by local agencies, high priority applicants do not apply, thinking that the program is not accepting any new persons."

Another large group that WIC Directors report they are not able to reach are those who mistakenly believe they are not eligible. As noted earlier, WIC income eligibility guidelines are set by the states and may range from 100 to 185 percent of poverty. Many of the women whose incomes are above the poverty level, but below the state's income limit, do not know that they and their children may qualify for WIC benefits. Yet these same women may be in very difficult economic straits because of low-paying jobs, high work-related expenses, health care costs (especially if they lack health insurance), and child care expenses.

VII. RECOMMENDATIONS FOR INCREASING PARTICIPATION IN THE WIC PROGRAM

A. OPTIONS FOR INCREASED FUNDING

It is clear that limited funding for WIC results in limited participation. The current funding level sustains about half of all individuals who are eligible for WIC.

In order to reduce the cost of the WIC food package and thus serve significantly more WIC participants, the majority of states, in recent months, have implemented strategies to purchase infant formula at less than retail cost. The April 1989, FRAC telephone survey sought to determine whether inadequate funding was still a significant problem in the WIC Program, considering the increased funds infant formula rebates bring into the program.

The vast majority (84 percent) of WIC Directors surveyed by FRAC reported that inadequate funding was a problem in their states. Even in states where infant formula rebates have been implemented (see page 24), most of the Directors reported that more funds were needed to increase WIC Program coverage.

Examples of the kind of problems they face include:

- "We are expanding rapidly due to infant formula rebates, yet still only 35 percent of those eligible are being served."
- "Like many states we can only serve a limited portion of the eligible population. We have waiting lists in almost all our counties."
- "Inadequate funding is absolutely a problem. Our infant formula rebate cost savings are being fully utilized and our caseload is at an all-time high. We're still receiving substantial requests for WIC services that cannot be met, and we've had to cut back on the priority levels we serve."
- "Even with money from infant formula rebates coming in, we may get to priority IV, but not V, VI, and VII [which include children with diet-based risks and all new mothers who do not breastfeed]."

A variety of mechanisms exist which can be employed to increase participation in the WIC Program so that all those eligible for WIC can receive the program's benefits.

1. Federal Funding

In the 100th Congress, a joint resolution was introduced in the House and Senate (H.J. Res. 192 and S.J. Res. 99) stating that "appropriations (for WIC) should be increased for

each succeeding year until all eligible persons are being served." More than 226 Members of Congress and 54 Senators signed onto this non-binding resolution.

The U.S. Department of Agriculture's National Advisory Council on Maternal, Infant, and Fetal Nutrition made a similar recommendation in 1986 -- that funding for WIC and its sister program, the Commodity Supplemental Food Program be incrementally increased to serve 100 percent of the eligible, women, infants and children by fiscal year 1992.[44] Similar recommendations have been made by:

- The Committee for Economic Development[45] (a group of more than 200 corporate executives and university presidents);
- The Council on Competitiveness[46] (a group of corporate executives and education and labor leaders);
- The National Commission to Prevent Infant Mortality[47] (a blue-ribbon panel chartered by Congress and chaired by former Senator Lawton Chiles);
- Former Presidents Gerald Ford and Jimmy Carter[48], in *American Agenda*, their 1988 report to the President-elect; and
- The Ford Foundation Project on Social Welfare and the American Future.[49]

In early 1989, more than 100 national organizations signed a petition (see Appendix B) supporting setting funding levels for WIC that would provide increments of $150 million plus inflation each fiscal year over the previous year's funding level for the next four to five years. This would allow approximately 300,000 more women, infants and children to be served by WIC nationwide in the first year alone. The list of petition endorsers included groups such as the American Academy of Pediatrics, the National Association of WIC Directors, the National Education Association, Bread for the World, World Hunger Year, the National Milk Producers Federation, the Center on Budget and Policy Priorities and the Food Research and Action Center.

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[44] U.S. Department of Agriculture, *1986 Biennial Report on the Special Supplemental Food Program for Women, Infants and Children and on the Commodity Supplemental Food Program*, Food and Nutrition Service, National Advisory Council on Maternal, Infant, and Fetal Nutrition, May 1987.

[45] Committee for Economic Development, *Children in Need: Investment Strategies for the Educationally Disadvantaged*, 1987.

[46] Council on Competitiveness, *Reclaiming the American Dream*, November 1988.

[47] National Commission to Prevent Infant Mortality, *Death Before Life: The Tragedy of Infant Mortality*, August 1988.

[48] Ford, Gerald and Jimmy Carter, *American Agenda: Report to the Forty-First President of the United States*, 1988.

[49] Ford Foundation Project on Social Welfare and the American Future, *The Common Good: Social Welfare and the American Future*, Ford Foundation, New York, 1989.

In recent years, WIC funding increases have made modest gains in reaching the unserved population. However, the program still serves only about half of those women, infants and children who are eligible. WIC is a "discretionary" program. This means that funding levels are determined through the appropriations process. Unlike the School Lunch Program, Medicaid, and Aid to Families With Dependent Children, WIC is not an entitlement program that must be funded to serve all who are eligible for and seek its services. WIC's ability to serve all those in need continues to be hampered by this lack of assured funding.

Because of WIC's extraordinary effectiveness, consideration should be given to placing WIC on par with other programs for low-income families. This would entail a phasing-in process with the goal of serving all eligible persons wishing to participate in the program. This can be done in a number of ways, including mandated spending levels, but however it is done, it will require relatively modest increases in funding over the next few years. Specifically, in order for WIC to come close to serving all the eligible women, infants and children who choose to participate, within as short a time frame as is logistically possible, only an additional $150 million per year above inflation -- a five to seven percent increase -- would be required for four to five years.

2. State Funding Options

States have been able to expand WIC participation using their own funds. (See Table 5.) Thirteen state agencies appropriated their own funds for WIC for fiscal year 1989. The largest state appropriation for WIC was in New York State, where the Supplemental Nutrition Assistance Program provided WIC with $35.8 million dollars for 1989.

Alaska, Arizona, Iowa, New Jersey and Rhode Island have maximized the use of federal WIC dollars by establishing "contingency funds" which allow their programs to more fully expend federal appropriations. It is very difficult for states to plan and control their caseloads over a year's time so that every federal WIC dollar is spent without overspending. Contingency funds provide a cushion for potential overspending. Without this spending cushion, many states have had to return a portion of their funding to the federal government at the end of the fiscal year because they were so cautious not to overspend. Contingency funds are a useful option, though they do not have the same potential for expanding the WIC Program as state supplementation of WIC funds. However, this may be the first step toward a financial commitment to WIC for many states. (Federal law allows states to use funds from the next fiscal year to cover current overexpenditures as long as the total amount transferred is not over one percent of the current year's budget.)

TABLE 5

State WIC Supplemental and Contingency Funds, FY 1989[50]

State Agency	Supplemental
Alaska	$ 242,000
D.C.	$ 600,000
Indiana	$ 200,000
Illinois	$ 6,000,000
Massachusetts	$ 8,100,000
Michigan	$ 396,000*
Minnesota	$ 700,000
New Hampshire	$ 100,000*
New York	$35,800,000
Pennsylvania	$13,000,000
Texas	$ 5,000,000
Washington	$ 350,000
Wisconsin	$ 2,200,000
State Agency	**Contingency**
Alaska	$ 42,000
Arizona	$ 100,000
Iowa	$ 200,000
New Jersey	$ 650,000
Rhode Island	$ 200,000

*For nutrition services and administration only.

[50]Source: Center on Budget and Policy Priorities.

State funding has been very helpful in some states. However, these local initiatives come nowhere near to meeting the total funding needs of the WIC Program. Increased federal appropriations continue to be vital to program expansion.

B. COST-SAVING MEASURES TO INCREASE THE NUMBERS SERVED

Recently, state WIC Programs have sought to increase participation through the use of cost-saving measures. Typically, these measures are aimed at reducing the cost of infant formula. Additionally, attention is being focused on the economic impact of increasing the percentage of WIC mothers who breast-feed. The 1989 Agricultural Appropriations Act required all states to study the feasibility of cost containment systems for all WIC foods and include their study results in their 1990 State Plans.

1. Infant Formula Rebates

Infant formula accounts for approximately one-third of the WIC food package cost on the national level. Prices for infant formula are higher than any other food item in the WIC package, and in recent years have risen at a faster rate than any other food item in the package.[51] In order to reduce the cost of the WIC food package and thus serve significantly more WIC participants, the majority of states have implemented strategies to purchase infant formula at less than retail cost or have begun the process to do so.

As of May 1989, 34 states and one Indian Tribal Organization using a retail purchase delivery system had secured rebates for infant formula. A majority of the other states are in the process of negotiating bids.

Twenty-one states have signed contracts for a competitive bid, or sole source, system. Under this system, the infant formula companies are encouraged to bid on state "requests for proposals" (RFPs) and the company offering the highest rebate per can will be the sole supplier of formula provided to WIC participants through retail stores.

Thirteen states and one Indian Tribal Organization have signed contracts to save money in purchasing infant formula through open-market rebate systems. With this system, the state negotiates an agreement with one or more infant formula companies to provide a specific rebate for each can of the company's formula sold to WIC infants. However, all companies may continue to sell their formula through the WIC Program, regardless of whether they are providing a rebate.

The savings from infant formula rebate contracts go directly from the contracting formula company into the state's WIC Program budget to expand and improve services.

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[51] Harvey, Stefan, Robert Greenstein and Scott Barancik, *Saving to Serve More: Ways to Reduce WIC Infant Formula Costs*, Center on Budget and Policy Priorities, September 1988.

The savings range from $250,000 a year in Wyoming to $4.8 million each month of California's three-year contract (totalling $172.8 million in savings over the life of the California contract). Rebates translate into greatly expanded participation -- for example, in California it will mean an average monthly increase of 100,000 participants.

The Center on Budget and Policy Priorities (CBPP) estimates that savings from rebates will ultimately allow WIC to serve 600,000 to 700,000 more participants than it would be able to without the rebates. The CBPP also estimates that 200,000 to 300,000 of these new participants have already been added with rebates. The remaining 300,000 to 500,000 that could still be added constitute only 14 percent of the eligible people currently estimated to be unserved by WIC. Additional funds from other sources are needed to serve the rest.

An additional concern raised by a number of State WIC Directors in FRAC's April 1989 telephone survey was the uncertain future of infant formula rebates. Typical of the concerns expressed by respondents are questions asked by two WIC Directors:

- "What will there be for us when the infant formula rebate is over? States may be becoming dependent on a temporary source of money and making rapid caseload increases. Will all of this crumble?"

- "Rebates have been a good thing. But what's going to happen downstream if the agreements are renewed at only a 50 percent level?"

2. Increasing Breastfeeding Rates Among WIC Mothers

Another mechanism to reduce formula costs (though to a much lesser extent than formula rebates) is to increase the percentage of WIC mothers who choose to breastfeed. Increased breastfeeding rates should save money over the long run by decreasing the need to purchase infant formula. According to the most recent estimates available, the average food package cost for a breastfeeding mother is $32.33 while cost of the infant food package containing formula is $43.99.[52]

Nutrition researchers and pediatricians agree that breastfeeding is the most desirable infant feeding method from a health and nutrition perspective.[53] But they also agree that those who are most likely to breastfeed are well-educated and well-to-do.[54] They

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[52]Correspondence, Ronald J. Vogel, Director, Supplemental Food Programs Division, Food and Nutrition Service, USDA, May 4, 1988.

[53]American Academy of Pediatrics, "The Promotion of Breast Feeding," (Policy Statement Based on Task Force Report), Pediatrics, Vol. 69, No. 5, 1982.

[54]Martinez, Gilbert A., and David A. Dodd, "1981 Milk Feeding Patterns in the United States During the First 12 Months of Life," *Pediatrics*, Vol. 71, No. 2, 1983.

also tend to be married, older and white.[55] The WIC population, on the other hand, is more likely to be less educated, poorer, single, younger and minority than is the general population.[56] As might be predicted from the demographic characteristics of WIC participants, they are less likely to breastfeed their babies than the general population.[57]

Effective promotional efforts to increase breastfeeding require additional staff training and time, and require extensive follow-up. These elements raise the cost of providing services. No additional WIC funds are currently provided to cover the increased costs of breastfeeding promotion. In order to encourage the promotion of breastfeeding through the WIC Program, funds should be earmarked for this purpose within the WIC Program budget.

C. MAKING WIC MORE ACCESSIBLE TO LOW-INCOME WOMEN, INFANTS AND CHILDREN

Even with increased funding, there will still be some barriers that stand in the way of many needy women, infants and children who are eligible to participate in the program. At minimal or no cost, these barriers can be eliminated in the following ways:

1. Allow all women, infants and children receiving Medicaid, AFDC or food stamps to be considered income-eligible for WIC.

Currently, when people receiving Medicaid, AFDC or food stamps apply for WIC, they must document their income again for WIC eligibility. Given that the income-eligibility requirements for these programs are more restrictive than for WIC, using Medicaid, AFDC or food stamp participation for presumptive income eligibility would eliminate a burdensome and duplicative step in the application process.

2. For income-eligibility purposes in WIC, allow a pregnant woman to be counted as a family of two, as she is in Medicaid.

This would increase the number of pregnant women on Medicaid who are eligible for WIC, as well as increase the overall number of low-income pregnant women who could receive WIC services. It would also help to improve the coordination between the two programs.

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[55]Rassin, David K., J. Richardson, T. Baranowski, P.R. Nader, N. Guenther, D.E. Bee, and J.P. Brown, "Incidence of Breast-Feeding in a Low Socioeconomic Group of Mothers in the United States: Ethnic Patterns," *Pediatrics*, Vol. 73 No. 2, 1984.

[56]U.S. Department of Agriculture, "Study of WIC Participant and Program Characteristics," 1986.

[57]Martinez, Gilbert A., "Infant Feeding in the United States," Marketing Research Department, Ross Laboratories, Columbus, Ohio, March 12, 1984.

3. Stipulate that state agencies are responsible for assuring that WIC clinics are accessible to working participants through extended/shifted office hours to include evening and/or weekend hours.

Many local WIC clinics are open during typical office hours (Monday though Friday, 9:00 a.m. to 5:00 p.m.). This creates a barrier to participation for working participants. A number of WIC clinics have avoided this barrier by extending or shifting their office hours so the clinic is open for a number of evening or weekend hours. This should be expanded to assure that more working participants have access to WIC clinics.

4. Eliminate the 60-day limit for the age of medical data (e.g., blood work) required for WIC eligibility.

In order to qualify for WIC benefits, applicants are required to provide proof that they are at nutritional risk. To document this condition, height, weight and blood tests are done by a "competent health professional". In September 1988, a regulation was issued which limits the age of medical data which are allowed to be used for WIC eligibility to 60 days. This has created a barrier for participants who are forced to return to a health care provider to have blood tests conducted a second time if the data from their "blood work" is more than 60 days old. The 60 day limit has been problematical because it is often logistically difficult, very inconvenient and time-consuming for participants to obtain another blood test. For children, it can be a traumatic experience. In addition, the cost of this second blood test often falls on the participant. Finally, there does not appear to be a strong medical basis for this restriction.

5. Stipulate that local agencies shall refer all women and children who apply for WIC, but cannot be immediately served, to other food, health and nutrition services (e.g., the Commodity Supplemental Food Program, food stamps, soup kitchens, TEFAP, Medicaid, etc.)

According to FRAC's 1989 survey, almost one-third of the 43 WIC Directors responding said that people placed on WIC waiting lists in their states are not referred to other services, or that they did not know whether local clinics referred these individuals to other services. This provision is needed to strengthen the referral aspect of the WIC Program, and to assure that women and children who are made to wait for WIC benefits are given a variety of other places to turn for assistance.

VIII. SUMMARY

The WIC Program is one of America's most successful public policy efforts. WIC participants are better-nourished, healthier and are in closer contact with the medical care system than those who are eligible but unserved. Babies born to mothers who participate in WIC during their pregnancies are less likely to be born preterm or at a low birthweight. A wealth of evaluation research exists which demonstrates WIC's health and nutrition benefits and its cost-effectiveness.

Congress intended that WIC would prevent health problems common among low-income women, infants and children as well as improve their current health status. When it reaches eligible people, WIC does both. Yet WIC serves only about half of those who are eligible, and no other program is available that can meet nutrition and health needs in the comprehensive way that WIC does.

The consequences of not meeting the health and nutrition needs of low-income, at-risk women, infants and children are grave. Our nation risks undernourished children with retarded growth, delayed cognitive development, and more illnesses; infants who are born too small to be healthy or develop normally; new mothers who never replenish nutrient stores that were depleted by their pregnancies. We miss excellent opportunities to educate young women about better nutrition for their families and we miss a very good chance to save money in medical bills for low birthweight infants and sick children.

The program's failure to serve all those eligible and wishing to participate is largely the result of inadequate funding. WIC appropriations have grown steadily since the program's inception, but at the current funding level only about half of those who are eligible are being served. Funding for the WIC Program will have to grow in order to serve all those who need its valuable services, and only through increased federal funding can the preventive nature of the program be fully realized.

Because of overall tight budget constraints, increments in WIC appropriations above inflation have been relatively modest in recent years and have fallen short of budget resolution assumptions. (See Appendix C). Strong consideration should be given to working toward serving all who are eligible for WIC and wish to participate as soon as is logistically possible. It appears that a phase-in of five to seven percent increases over inflation each year could put WIC at that threshold by 1995.

APPENDIX A

Federal Funding vs. Administration Requests[58]

FY 1980 to FY 1989
(in millions)

Fiscal Year	Administration Request	Actual Federal WIC Funding (in millions)
1980	$ 750.0	$ 750.0
1981	$ 900.0	$ 900.0
1982	$ 637.5	$ 904.3
1983	$ 637.5[59]	$1,160.0
1984	$1,060.0	$1,360.0
1985	$1,254.3	$1,500.0
1986	$1,479.8	$1,580.5
1987	$1,617.0	$1,663.5
1988	$1,687.5	$1,802.4
1989	$1,871.0	$1,929.4

[58]Sources: Congressional Research Service, Committee on Ways and Means, *Congressional Quarterly*, President's Budget Request (FY 1988), Center on Budget and Policy Priorities.

[59]For fiscal year 1983, the Administration proposed to terminate a separate line item for the WIC Program and include its funding as part of the Maternal and Child Health Block Grant (MCH). This figure is an estimate of what the WIC funding would have been, based on the proportion of funds appropriated for WIC and MCH the previous fiscal year.

APPENDIX B

Petition for Assured WIC Funding Increase

Whereas, the Special Supplemental Food Program for Women, Infants and Children (WIC) provides supplemental food, nutrition education and referral to health care to low income pregnant women, new mothers and young children at nutritional risk;

Whereas, the WIC program was designed to be a preventive program to safeguard the health and well-being of these groups of people who are at critical growth periods;

Whereas, research findings have shown that WIC participation has resulted in a reduction in the late fetal death rate, a reduction in the chances of having a baby born at low birthweight, fewer premature births, an increase in the number of women seeking early prenatal care, an increase in the head size of infants born to WIC participants, and appears to lead to better cognitive performance in children;

Whereas, the WIC program was found to be cost-effective by a study conducted at the Harvard School of Public Health showing that each $1 spent on the prenatal component of WIC saved $3 in hospitalization costs associated with low birthweight and by a study conducted by the Missouri Department of Health which found that every $1 invested in WIC's prenatal component saved 49 cents in Medicaid costs for newborns during the first 45 days of life;

Whereas, in the last year and a half, the Committee for Economic Development, the National Commission to Prevent Infant Mortality, the *American Agenda* report from former Presidents Gerald Ford and Jimmy Carter to the President-elect, and the Council on Competitiveness have all made recommendations for major WIC expansion;

Whereas, WIC enjoys strong bi-partisan support in Congress, where in 1987, a bi-partisan group of more than 200 members of the House of Representatives signed a letter calling for funding increases, while in 1988, more than 60 Senators signed similar letters;

Whereas, in 1988, over 75,000 Americans signed a Campaign to End Hunger and Homelessness petition urging WIC funding for all eligible women, infants and children by the end of this presidential term;

Whereas, primarily due to inadequate federal funding, the WIC program currently serves only about half of the women, infants and children who are eligible;

Whereas, in order to reach women, infants and children who are currently eligible but unserved, WIC funding needs to be increased in sure and steady increments over several years and states need to be able to count on and plan for these increments;

Whereas, the current "discretionary" funding nature of WIC often makes it impossible for states to know their WIC funding level for a fiscal year until several months into the year and can subject program funding to fluctuation;

Whereas, the reauthorization of the WIC program during 1989 can modify the funding procedures used in the program and establish funding levels for the program for the next four to five years;

Therefore, be it resolved, the organizations listed below support establishing WIC as a "mandatory" spending program with a specific funding level for each year that is covered by the reauthorization; and,

Further, be it resolved, the listed organizations support setting the funding at levels that would provide increments of $150 million plus inflation each fiscal year over the previous year's funding level.

National Organizations Endorsing the Petition for Assured WIC Funding Increase

Amalgamated Clothing and Textile Workers Union
American Academy of Pediatrics
American Association of School Administrators
American College of Nurse Midwives
American Dietetic Association
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Home Economics Association
American Medical Student Association
American Nurses Association
American Public Health Association
American School Food Service Association
Americans for Democratic Action
Association for Retarded Citizens of the United States
Association of Community Organizations for Reform Now
Association of Junior Leagues
Bread for the World
Catholic Charities - USA
Center for Community Change
Center for Law and Social Policy
Center for Science in the Public Interest
Center on Budget and Policy Priorities
Child Welfare League of America
Children's Defense Fund
Children's Foundation
Clergy and Laity Concerned
Coalition on Human Needs
Communications Workers of America
Community Nutrition Institute
Congress of National Black Churches
Consumer Federation of America
Council of Chief State School Officers
Council of Great City Schools
Department of Human Welfare, General Board of Church and Society, United Methodist Church
Epilepsy Foundation of America
Family Service America
Food Research and Action Center
Friends Committee on National Legislation
Full Employment Action Council
Gray Panthers
Interfaith Action for Economic Justice

International Association of Fire Fighters
International Federation of Professional and Technical Engineers
International Ladies Garment Workers Union
International Reading Association
Jesuit Social Ministries, National Office
Jobs with Peace Campaign
Lutheran Office for Governmental Affairs
March of Dimes Birth Defects Foundation
Mennonite Central Committee, Washington Office
National Anti Hunger Coalition
National Association for Retarded Citizens
National Association of Community Action Agencies
National Association of Community Health Care Centers
National Association of Homes for Children
National Association of Social Workers
National Association of State Agencies for Food Distribution
National Association of Wheat Producers
National Association of WIC Directors
National Black Caucus of State Legislatures
National Coalition for the Homeless
National Committee for Citizens in Education
National Community Action Foundation
National Conference of State Legislatures
National Congress of American Indians
National Consumers League
National Council of Catholic Women
National Council of Jewish Women
National Council of La Raza
National Council on the Aging
National Council of Senior Citizens
National Education Association
National Family Farm Coalition
National Farmers Union
National Grange
National Milk Producers Federation
National Organization for Women
National Perinatal Association
National PTA
National Puerto Rican Coalition
National Rural Health Association
National Rural Housing Coalition
National Student Campaign Against Hunger
National Urban League
National Welfare Rights Union
National Women's Law Center
National Women's Political Caucus
NETWORK: A Catholic Social Justice Lobby

Office of Public Policy, Women's Division, United Methodist Church
Planners Network
Project Vote
Public Voice for Food and Health Policy
Results
Religious Action Center
Rural Coalition
Service Employees International Union
Society for Nutrition Education
Unitarian Universalist Association of Congregations in North America, Washington Office
United Auto Workers
United Church of Christ, Office for Church in Society
United Food and Commercial Workers
United Mine Workers of America
U.S. Catholic Conference
U.S. Conference of Mayors
Villers Advocacy Associates
Washington Office, Church Women United
Washington Office, Episcopal Church
Washington Office, Presbyterian Church USA
World Hunger Year
YWCA of the USA

APPENDIX C

Federal WIC Funding vs. Budget Resolution Assumptions[60]

FY 1986 to FY 1990
(in billions)

WIC is a discretionary program. This means that its funding levels are determined through the appropriations process. Overall spending targets and limits are set by the Congressional Budget Resolution. Although it is true that if increased funding for the WIC Program is not in the Budget Resolution, it is difficult to obtain increased appropriations for the program, it is also true that increased WIC appropriations do not necessarily follow just because money for the program is in the budget. There are tight budget constraints within which the Appropriations Committees must work, and various funding needs must be balanced. Over the last few years, WIC has received both increases to cover inflation and real funding increases that allow some increases in caseload. However, appropriations have fallen short of budget resolution assumptions, and WIC still falls far short of being able to serve all people who are eligible and wish to participate.

Fiscal Year	Congressional Budget Resolution Assumptions	Final Appropriation Level
1990	$2.158	Pending
1989	$2.024	$1.929
1988	$1.865 (Senate) $1.815 (House)	$1.802
1987	$1.697	$1.663
1986	$1.629	$1.580

[60] Sources: Congressional budget and appropriations documents.